Within the framework for strengthening early childhood mental health and social-emotional development, prevention includes screening and targeted supports. Screening provides a mechanism to identify primary care providers, especially mothers, and children at risk of or in need of social-emotional and mental health supports. Once identified, targeted supports include social and emotional supports to prevent or resolve outstanding concerns. For parents, this includes brief counseling and support for mild mental health or substance use problems. For children, prevention and early intervention strategies include explicit instruction in social skills and emotional regulation. Comprehensive treatment for parents and children with more intensive social-emotional and mental health needs is discussed in Chapter 5.

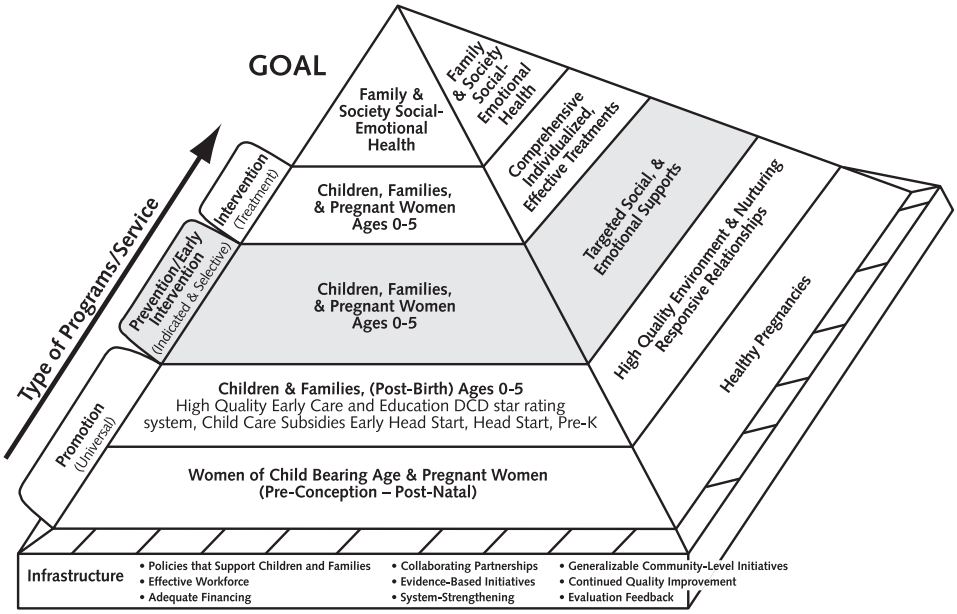
Within the framework for strengthening early childhood mental health and social-emotional development, prevention includes screening and targeted supports.

Prevention Through Early Intervention With Primary Caregivers of Young Children

Maternal Depression

Approximately 10-20% of mothers are affected by prenatal and postpartum depression.[1] The percentage rises to 60% for teens and other mothers who

Figure 4.1
Pyramid for Strengthening Early Childhood Mental Health and Social Emotional Competence in Young Children



Note. This pyramid model conceptualizes the critical building blocks for achieving healthy mothers and healthy children. The front face of the pyramid explains the individuals and families who receive programs and services, which are divided up by the following categories: promotion, prevention, and intervention. The pyramid's side face lists the goals associated with the program/service recipients(s). these are further divided according to the socioecological model of health behavior. The foundation of the pyramid represents the necessary system-building blocks.

have low incomes.[2] Prenatal depression can negatively affect the health of the mother and developing child as well as contribute to poor fetal attachment. Pregnant women with depression also are more likely to engage in risk-taking behaviors, such as substance abuse, and may decrease compliance with prenatal care.[1] Pregnant women with depression are more likely to deliver preterm and low birthweight babies.[1] Untreated prenatal depression is also associated with increased rates of maternal suicide.[1]

Approximately 10-20% of mothers are affected by prenatal and postpartum depression.

Postpartum depression is the most common complication associated with childbirth. Postpartum depression negatively affects the health of the mother and can permanently impact the health and development of the infant.[1] Mothers suffering from postpartum depression may experience unbearable loneliness, insecurity, anxiety attacks, and guilt along with feeling sad, useless, helpless, and hopeless. Postpartum depression leads some mothers to isolate themselves. In order to escape depression, some may have thoughts of using violence towards themselves or their baby.[3] Mothers experiencing depressive symptoms retain more negative perceptions of their baby and of their performance as a mom.

Depression after childbirth impedes maternal emotional health and impairs parenting. Because mothers are emotionally disengaged, bonding and creating a positive mother-infant relationship is disturbed. Mothers who are depressed play less frequently with their infants and have fewer verbal interactions with them, which impairs development.[4] Postpartum depression compromises the mother's ability to care for and develop a healthy relationship with her child, which is critical for healthy infant development. Often there is less positive attribution of the child and increased child behavior leading to irritability and hostility. Interaction is compromised; there can be less sensitive and attuned interactions. That is, mothers may be more controlling or apathetic to the baby and indifferent to caregiving. Because the mother may be withdrawn, there can be disturbed social interactions. There is also impeded attention to and judgment for infant health and safety. Infants whose mothers have postpartum depression are more likely to have delayed social-emotional, cognitive, and linguistic development as well as long-term mental health problems.[1] Essentially, they do not get their needs for consistent emotional nurturance, appropriate stimulation, and protection met. Adoptive parents and fathers can also experience depression. The mental health of all primary caregivers impacts the quality of care they provide and, in turn, impacts the child's development and well-being.[1]

Many women are afraid to talk about depression with their health providers and many health providers do not screen for depression.

Unfortunately, many women are afraid to talk about depression with their health providers and many health providers do not screen for depression. Women report mistrust and fear of judgement as reasons for not discussing depression with their health care providers.[1] Providers also report barriers including lack of training to diagnose, counsel, and treat depression; inadequate time; limited treatment options due to lack of or inadequate insurance coverage; and a lack of mental health professionals available for referral.[1] Many tools exist to screen for depression among adults, including mothers before and after birth. A number of

groups recommend screening pregnant and postpartum women including the US Preventive Services Task Force, the American Congress of Obstetricians and Gynecologists (ACOG) Committee on Obstetric Practice , and the American Academy of Pediatrics Bright Futures. Screening is only effective if adequate treatment and follow-up resources are available and affordable, which is not the case in many areas and for many women.[1]

Health insurance plans, both public and private, are well positioned to help increase the detection and treatment of maternal depression. By encouraging providers to screen for maternal depression, educating patients, and covering mental health treatment services and care coordination, health plans could have a substantial impact on detection and treatment. (See Recommendation 5.2 in Chapter 5.) As part of the Medicaid Pregnancy Medical Home Initiative, women receiving Medicaid receive a prenatal and postpartum depression screening. Under the Patient Protection and Affordable Care Act (ACA), preventive screenings, including prenatal and postpartum depression screening, must be covered by insurers at no cost to patients.(For further discussion of treatment for maternal depression, see Chapter 5.)

Health insurance plans, both public and private, are well positioned to help increase the detection and treatment of maternal depression.

In addition to screening for maternal depression as part of health care provided to the mother, there is increasing interest in screening mothers as part of infant well-baby visits. Since the early identification of women at-risk for postpartum depression may lead to a decrease in long-term negative effects on child development, the American Academy of Pediatrics (AAP) recommends that pediatricians screen mothers for postpartum depression at baby's 1, 2, and 4 month visits.[5] The Bright Futures guidelines, a set of health supervision guidelines to direct the provision of health care to children from the prenatal period through age 21, recommend screening mothers for depression at baby's 1, 2, and 6 month visits.[6] The Affordable Care Act mandates that all private insurance plans (except for those that are considered "grandfathered plans") must provide coverage of the Bright Futures clinical preventive services for infants, children and adolescents without any cost sharing.[a]

Current North Carolina Efforts to Screen for Depression

Community Care of North Carolina's (CCNC) Pregnancy Medical Home (PMH) requires all contracted providers to use a standardized risk screening assessment to identify patients at high risk for pre-term birth. Contract PMH providers receive $50 for completing the initial screen during pregnancy and $150 for completing the postpartum visit.[7] Mothers whose children receive Medicaid can be screened for depression as part of infant well-child visits, however there is no compensation for screening parents. However, parents can be seen under their child's Medicaid coverage for up to six mental health visits with a primary care provider, licensed clinical social worker, psychiatrist or psychologist.[2]

a Patient Protection and Affordable Care Act, Pub L No. 111-148, §1001, amending Sec. 2713 of the Public Health Service Act, 42 USC 300gg-13.

Maternal Substance Use

Substance use during pregnancy is linked to poor pregnancy outcomes. Substance use includes alcohol, tobacco, misuse of prescription drugs, and the use of illicit substances such as methamphetamines, marijuana, and cocaine. While all substance use during pregnancy can harm fetal development, alcohol produces the most serious fetal brain impairment.[8] Therefore, the Task Force focused most heavily on maternal alcohol use. However, all types of maternal substance use can negatively affect fetal development and parenting skills. Alcohol is the example used in this report, but the recommendations around substance use apply to all substances, not just alcohol.

Alcohol use during pregnancy is the leading cause of preventable birth defects associated with mental and behavioral impairment.

The risks of alcohol use during pregnancy have been studied in depth and are well understood. The use and abuse of alcohol during pregnancy poses the same risks as alcohol use in general for the women, including unintentional injuries, violence, and poisoning as well as negative long-term health problems.[9] However, alcohol use poses even greater risks to the developing fetus. When a pregnant woman drinks alcohol, it passes across the placenta to the fetus, thus impairing fetal development. Drinking alcohol during pregnancy may lead to pregnancy complications such as miscarriage, stillbirth, or premature delivery.

Alcohol use during pregnancy is the leading cause of preventable birth defects associated with mental and behavioral impairment.[10] Alcohol use during any stage of pregnancy can harm the developing fetus. A pregnant woman who drinks any alcohol is at risk for having a child with a fetal alcohol spectrum disorder (FASD). One in eight pregnant women report alcohol use in the past 30 days and 2% report binge drinking.[11] In 2009 in North Carolina, 50% of pregnant women reported drinking in the three months prior to pregnancy and 8% reported alcohol use during the final three months of pregnancy.[12]

The US Surgeon General advises all pregnant women and women who may become pregnant to abstain from alcohol.[10] FASDs, including alcohol-related birth defects and alcohol-related neurodevelopmental disorder, are estimated to occur in 10 live births per 1,000 births in the US each year, which equates to more than 12,000 cases per year in North Carolina. [10,13] Although no cure exists, FASDs are 100% preventable by completely avoiding alcohol consumption during preconception and pregnancy. Currently, no "safe" level of alcohol use during pregnancy has been established. During the first three months of pregnancy, alcohol appears to be the most harmful. While drinking at any point during pregnancy is risky, consuming larger amounts of alcohol (including binge drinking) appears to increase the risk of harm more than drinking small amounts of alcohol.[14]

Fetal alcohol syndrome (FAS) is the most severe FASD diagnosis. FAS occurs in approximately one to two live births per 1,000 births in the US, which equates

to more than 200 births per year in North Carolina.[15,16b] To meet the criteria for diagnosis, maternal alcohol use must be confirmed, the infant or child must possess a characteristic set of facial anomalies, and there must be evidence of growth retardation and brain abnormalities.[17] An individual with FAS may have the following complications: abnormal heart structure; behavior problems; mental retardation; problems in structure of the hands, eyes, nose, or mouth; poor growth before birth; slow growth and poor coordination after birth; and, in severe cases, the infant may die soon after birth.[14] FAS is not limited to a childhood disorder because exposure to alcohol as a fetus can result in lifelong mental and physical disabilities and may increase the risk for later alcohol, tobacco, and other drug dependence in adults.[18-20]

In addition to causing problems during pregnancy, postpartum substance use can negatively impact the social-emotional well-being and development of young children. The 2007 National Survey on Drug Use and Health found that 14% of children ages 0-5 lived with a parent who abused or was dependent on alcohol or an illicit drug.[21] Parental substance use can lead to chaotic, unpredictable home environments, which impairs young children's social-emotional development,[21] and disrupts the bonding process that is so critical for development. Substance use impairs parents' ability to engage in nurturing, responsive relationships and to provide high quality environments that are essential for the social-emotional development and mental health of young children.[21]

Postpartum substance use can negatively impact the social-emotional well-being and development of young children.

Parental substance abuse and dependence is a complex and costly chronic illness that has significant ramifications for children. Screening pregnant women and parents of young children is the first step towards providing appropriate medical intervention—whether brief or intensive. Screening typically involves using a limited set of questions to identify if conditions exist and whether more thorough evaluations and referrals are needed.[22] There are many avenues for treatment depending on the severity of the problem. Early interventions are needed for parents who have not yet become addicted but are at risk for addiction; treatment is needed for those who are addicted. (See Chapter 5 for more on treatment.) Improved identification of substance use prior to or early in pregnancy can reduce prenatal substance dependency and its devastating effects on the mother and developing fetus. Utilizing consistent evidence-based medical protocols for parents or other caretakers who are at risk for substance

b Birth defects linked with alcohol use during pregnancy are called Fetal Alcohol Spectrum Disorders (FASD). Disorders grouped as FASD include Fetal Alcohol Syndrome (FAS), Alcohol-Related Neurodevelopmental Disorder (ARND), Alcohol-Related Birth Defects (ARBD) and Partial Fetal Alcohol Syndrome (PFAS). These birth defects include physical, mental, behavioral and/or learning disabilities.2 Birth defects linked with alcohol use during pregnancy are called Fetal Alcohol Spectrum Disorders (FASD). Disorders grouped as FASD include Fetal Alcohol Syndrome (FAS), Alcohol-Related Neurodevelopmental Disorder (ARND), Alcohol-Related Birth Defects (ARBD) and Partial Fetal Alcohol Syndrome (PFAS). These birth defects include physical, mental, behavioral and/or learning disabilities. For more information, see: Program, The North Carolina Teratogen Information Service and Fetal Alcohol Prevention. (2011). *Alcohol During Pregnancy*. Accessed 30, 2012, from NC Pregnancy.org

abuse problems can positively impact the social-emotional development and mental health of young children.

The most common way to identify substance abuse risk during pregnancy and postpartum is through the use of screening methods including self-report, interview, and observation. The American College of Obstetricians and Gynecologists recommends providers screen all pregnant women for substance use, abuse, and dependency.[23] However, many providers do not screen for substance use. As with maternal depression, screening is only effective if adequate treatment and follow-up resources are available and affordable which is not the case in many areas and for many women. CCNC has been promoting the use of an evidence-based screening, brief intervention, and referral into treatment (SBIRT) protocol in primary care practices throughout the state. Early identification is a critical first step toward engaging substance dependent parents in treatment.

Utilizing consistent evidence-based medical protocols for parents or other caretakers who are at risk for substance abuse problems can positively impact the social-emotional development and mental health of young children.

Current North Carolina Efforts to Reduce and Screen for Prenatal and Postpartum Substance Abuse

As part of the North Carolina Medicaid Pregnancy Medical Home Model, pregnant women receiving Medicaid are screened for tobacco and substance abuse. A positive screen triggers a more thorough assessment as well as care management to help ensure women receive appropriate treatment services.[7] The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services funds prenatal and maternal substance abuse programs, through the North Carolina Perinatal and Maternal Substance Abuse Initiative, which are specifically designed to meet the needs of women who are using substances while they are pregnant and/or parenting and the needs of their children. More information on these programs is available in Chapter 5.

North Carolina's Fetal Alcohol Prevention Program and the North Carolina Teratogen Information Service provide prevention education to pregnant women, women of child-bearing age, significant others, and the professionals who work with them about the dangers of substance use during pregnancy. Information on referral sources is also made available. The North Carolina Teratogen Information Service, housed at Mission Hospital's Fullerton Genetics Center in Asheville, maintains a confidential toll-free information service, the Pregnancy Exposure Riskline (1-800-532-6302), to answer questions and provide information on exposures (i.e., alcohol, medications, illegal substances, environmental chemicals, and other harmful substances). North Carolina's Fetal Alcohol Prevention Program also provides training for professionals and caregivers of children with FASD and resources for professionals and families regarding children with suspected or confirmed diagnoses of FAS or FASD.

Family Violence

Family violence, including physical, emotional, and sexual abuse, negatively affects children's mental health and social-emotional well-being when the

violent behavior is directly inflicted on the mother and/or the child, and when the child witnesses family violence on his or her mother.[24] Half of domestic violence cases include children under the age of 5.[25] Studies have found that during an occurrence of family violence, a child is present 85-90% of the time. Of those children who witnessed family violence, 50% were also abused directly.[26] The Adverse Childhood Experiences (ACE) Study found that 22% of adults were victims of sexual abuse as a child, 13% witnessed their mothers or step mothers treated violently, 11% suffered recurrent physical abuse, and 11% suffered from emotional abuse during their childhood.[27]

In North Carolina, 4.4% of women reported abuse during pregnancy.[28] Pregnant women and mothers affected by family violence are more likely to suffer depression and anxiety, and have trouble parenting, have lower self-esteem, and have trauma symptoms.[29] Mothers' mental health problems resulting from family violence situations directly affect their parenting ability. Mothers may be compromised in their ability to understand the ongoing needs and experiences of their child, show affection towards their child, and focus on their child's personality and behavior characteristics.[29] Mothers who are victims of family violence have a more negative representation of themselves and their infants, and are less securely attached to their infants.[30] High levels of the stress hormone cortisol during pregnancy, in combination with low mother-infant attachment, are associated with impaired cognitive development in infants.[31] Additionally, women who are abused are six times more likely to be diagnosed with substance abuse problems, and three times more likely to be diagnosed with depression compared to women who are not abused.[32] As discussed, substance abuse and depression interfere significantly with mothers' ability to care for their children.

Mothers' mental health problems resulting from family violence directly affect their parenting ability.

Exposure to family violence compromises the emotional, physical, social, and cognitive well-being of children. Children experience behavior changes such as excessive irritability, sleep problems, emotional distress, fear of being alone, immature behavior, and problems with toilet training and language development. In one study, children exposed to family violence had 40% lower reading abilities at early ages.[24] Children exposed to family violence are at higher risk for alcoholism and alcohol abuse, chronic obstructive pulmonary disease, depression, fetal death, health-related quality of life, illicit drug use, ischemic heart disease , liver disease, intimate partner violence, multiple sexual partners, sexually transmitted diseases, smoking, suicide attempts, unintended pregnancies, early initiation of smoking, early initiation of sexual activity, and adolescent pregnancy.[24,24,24] Studies have shown that infants and young children exposed to severe family violence show symptoms of post-traumatic stress disorder. [33] National data shows that compared to the national average, children who are exposed to family violence are 15 times more likely to be physically and/or sexually assaulted. Children who grow up in environments with family violence are also more likely to use family violence as a way to dominate their interpersonal relationship, thus creating a cycle of family violence.[24]

Exposure to family violence compromises the emotional, physical, social, and cognitive well-being of children.

In 2010, 126,612 children received assessment for child abuse and neglect in North Carolina. Additionally, 6.8% of the children in North Carolina suffered recurrent maltreatment.[34] Infant victims of family violence often have significantly delayed brain development. The brain of the child exposed to interpersonal violence increases activity in the "survival" portion of the brain, thereby depriving resources from other parts of the brain. The parts of the brain that are deprived of energy during early development fail to form and the child loses neuronal synapses in these regions. Research has shown reduced neuronal mass in the brains of abused children for areas where executive functioning, rational thinking, and decision-making occur, exacerbating the children's irrational behavior, and lack of appropriate executive functioning and decision making.[25]

Improved identification and, when applicable, brief intervention or referral to treatment should help reduce the devastating effects of mental health problems, substance use, and family violence on young children and their families.

Current North Carolina Efforts to Reduce Family Violence

As with maternal depression and substance use, through coverage of screening for family violence, educating patients, and mental health treatment services and care coordination, health plans could have a substantial impact on detection and treatment.(See Recommendation 5.2.) As part of the North Carolina Medicaid Pregnancy Medical Home Model, pregnant women receiving Medicaid are screened for family violence. A positive screen triggers a more thorough assessment as well as care management to help ensure women receive appropriate treatment services.[7] The American College of Obstetricians and Gynecologists recommends screening pregnant women for domestic violence and the American Academy of Pediatrics recommends screening parents for family violence.[35,36] Under the Affordable Care Act (ACA), screening and counseling for interpersonal domestic violence must be covered by insurers at no cost to patients.[37] Additionally, under the Bright Futures Recommendations for Preventive Pediatric Health Care, which are used to guide pediatric care provided as part of North Carolina's Medicaid program and will be used to guide care provided through private insurance under the ACA, young children should be screened for family violence at their initial visit and yearly thereafter.

Family Preservation Services, funded by the North Carolina Division of Social Services (DSS) through the Federal Family Preservation and Family Support Services Program, provides short-term, intensive in-home services to prevent children at-risk for placement outside of the home from being removed from the home. Young children who are alleged or found to have been abused or neglected, have emotional or behavioral disturbances, or have medical needs that, with assistance, could be met at home are eligible.[38] DSS also provides funding to local Departments of Social Services to support Family Violence Prevention Services which provide programs to prevent family violence and to provide shelter and assistance to victims of family violence.

Improving Screening and Early Intervention for Primary Caregivers of Young Children

Screening pregnant women and parents of young children is the first step towards providing appropriate intervention for mental health, substance use, and family violence—whether brief or intensive. Improved identification and, when applicable, brief intervention or referral to treatment should help reduce the devastating effects of mental health problems, substance use, and family violence on young children and their families. There are many avenues for treatment, depending on the nature and severity of the problem. Early interventions may be appropriate in some cases, whereas others will need more intensive treatment, as discussed in Chapter 5. Utilizing consistent evidence-based protocols to provide screening, triage, referrals, and treatment can positively impact the social-emotional development and mental health of young children. Therefore, the Task Force recommends that North Carolina establish care and reimbursement standards to promote women and children's mental health. (See Recommendation 5.2)

Children with Social-Emotional and Mental Health Needs

Most young children will master the major social-emotional developmental tasks during the first five years without difficulty. However, a significant number of young children will experience difficulties mastering these tasks. Children experiencing difficulties exhibit atypical, and often challenging, behaviors. In an infant, such behaviors may include excessive crying, being hard to soothe, and exhibiting a lack of engagement in social interactions and play.[39] Among toddlers and preschoolers, such behaviors may include trouble eating or sleeping; being unusually quiet or withdrawn; engaging in destructive behaviors such as hitting, fighting, and screaming frequently; and having difficulty forming relationships with caregivers, teachers, and peers. While most children experience phases of fussiness, anxiety, disobedience, tantrums, and even aggression, such phases are typically short and situation specific. Children going through phases of challenging behavior and their parents can be helped by brief interventions aimed at preventing or resolving such behaviors. Persistent, intense, and pervasive challenging behaviors in young children indicate social-emotional and mental health needs that warrant more intense intervention. (For more information on intervention, see Chapter 5.) Early identification and treatment can have a profound and positive effect on social-emotional problems as well as improve outcomes for children with serious disorders.[40] Within the framework used by the Task Force for strengthening early childhood mental health and social-emotional development, prevention includes early identification and brief intervention.

Early identification and treatment can have a profound and positive effect on social-emotional problems as well as improve outcomes for children with serious disorders.

Screening for Social-Emotional Development and Mental Health Needs

The first step to providing effective intervention and treatment for young children is identifying the problem. There are a number of effective evidence-based

screening tools to identify atypical and delayed social-emotional development. Some can be completed by parents as part of a health visit or by other caregivers or teachers. Others must be administered by trained professionals. Children that are identified as having social-emotional needs may need a brief intervention or may need more intensive clinical treatment. Brief interventions, including consultations with the child's parent(s) on how to manage specific challenging behaviors, could occur as part of a routine health visit, a meeting with a social worker, or in consultation with a psychologist or school counselor. Children with more intense social-emotional and mental health needs may need to be referred for further assessment by a professional. The professional can provide a more detailed diagnosis and work with the family or caregivers to develop an appropriate treatment plan. Currently, there is no standard process for screening, brief intervention, referral, assessment, and treatment. Because of the critical role that screening and brief intervention play in identifying and treating young children with social-emotional and mental health needs, the Task Force recommends that North Carolina establish care and reimbursement standards to promote women and children's mental health. (See Recommendation 5.2)

Currently, there is no standard process for screening, brief intervention, referral, assessment, and treatment.

As with maternal depression and substance use, health insurance plans, both public and private, are well positioned to increase the detection and treatment of young children's social-emotional and mental health needs. By encouraging providers to screen for atypical or delayed social-emotional development and by covering brief interventions, intensive treatment services, and care coordination, health plans could have a substantial impact on detection and treatment. (See Recommendation 5.2.)

The American Academy of Pediatrics and the Maternal and Child Health Bureau of the Health Resources and Services Administration of the US Department of Health and Human Services have developed Bright Futures. Bright Futures Recommendations for Preventive Pediatric Health Care [6] provides theory- and evidence-based guidelines for providing preventive pediatric care. Bright Futures recommends providers perform basic psychosocial and behavioral assessments as well as developmental surveillance at all young child preventive visits. Such assessments and surveillance can be done through observation and discussion with parents or through the use of screening tools. Bright Futures recommends the use of a developmental screen at the 9, 18, and 30 month visits. North Carolina's Medicaid child health program currently covers the preventive care services outlined in Bright Futures. Under the ACA, private health plans will be required to cover the preventive care services outlined in Bright Futures at no cost.

In addition to following the Bright Futures guidelines in the Medicaid program, North Carolina's Assuring Better Child Health and Development (ABCD) Project has worked to increase the use of practical, standardized, and validated screening tools. The ABCD project has worked with CCNC networks to promote developmental, social-emotional, and autism screening tools as well

as a maternal depression screen as part of young child visits.[41] The project began with the developmental screen in 1999 when only 15% of children ages 0-2 receiving Medicaid received such screenings. By 2008, 85% of children ages 0-5 receiving Medicaid received a developmental screen.[41]

Family Strengthening and Parenting Skills Promotion

All children need adult guidance on how to appropriately express their emotions, play cooperatively with peers, and on how to solve social problems. However, some children will need systematic and focused instruction to learn specific social-emotional skills including self-regulation, expressing and understanding emotions, and friendship skills. With the right skills, parents and other caregivers, early care and education providers, and others can provide explicit instruction in social skills and emotional regulation. Children who have trouble controlling anger need to be taught strategies to calm down. Children who have difficulty making friends can be taught skills such as sharing, taking turns, requesting and receiving help, and giving compliments. Research shows that young children who have the ability to recognize and understand feelings in oneself and others are healthier, less lonely, engage in less destructive behavior, and have greater academic achievement.[42] Parents and other caregivers and educators can teach children the skills needed to have a strong emotional vocabulary. For example, adults can read books or play games to help children identify different emotions in themselves and others. Through consultations and skills training, parents and other caregivers and early care and education providers can learn how to provide this type of instruction for young children. Preventive evidence-based family strengthening and parenting skills programs can help foster the kind of enriching home environment, secure relationships, and interactions that promote young children's social-emotional development and mental health.

Preventive evidence-based family strengthening and parenting skills programs can help foster the kind of enriching home environment, secure relationships, and interactions that promote young children's social-emotional development and mental health.

North Carolina Efforts to Provide Prevention Services

Home Visiting Programs

Home visiting programs are an effective way to provide a wide array of services and supports to pregnant women and new families. Home visiting programs send nurses, social workers, or other professionals into the homes of families considered at-risk to assess needs and to help families connect to services and supports including health care, early intervention, and parenting skills classes. These programs have been shown to improve maternal and child outcomes.[43] Currently North Carolina has a variety of nurse home visiting programs that target parents before and after birth, as well as low-income, teenage, and other at-risk families. Participation in these programs is voluntary and programs are often staffed by trained peers from the community being served.

North Carolina has four evidence-based home visiting programs: the Nurse Family Partnership (NFP), Healthy Families America (HFA), Early Head Start Home-Based Program Option (EHS), and North Carolina Parents as Teachers (PAT).(See Appendix B for more information about these programs.)

These programs are offered in various counties throughout the state. NFP is administered in 10 sites and serves 16 counties across the state (Buncombe, Cleveland, Columbus, Edgecombe, Gaston, Guilford, Halifax, Hertford, McDowell, Mecklenburg, Northampton, Pitt, Polk, Robeson, Rutherford, and Wake). By the end of 2012, NFP will expand to 11 sites serving 17 counties (with the addition of Forsyth). There are six HFA affiliated sites in eight counties across the state (Burke, Durham, Mecklenburg, Mitchell, Nash, Rowan, and Yancey). Each site offers slightly different services in response to varying family and community needs. Last year, North Carolina's EHS served 3,700 children and 379 pregnant mothers in 39 counties with 29 agencies. PAT is an evidence-based curriculum used throughout the state. Funding for these programs comes from federal, state, and local governments as well as private foundations and other organizations.

There is a great need for evidence-based in–home and out-of-home programs to improve family functioning and parenting skills and to help families connect with needed services and supports.

In June 2011, the North Carolina Maternal, Infant and Early Childhood Home Visiting Program was awarded $3.2 million per year for three years to fund nine-community grant recipients. Currently, 7-community grant recipients serving 25 counties are funded. (The grant can also support an additional two programs.)[c] The grant is intended to connect families considered at-risk to services that can improve a "child's health, development, and ability to learn – such as health care, developmental services for children, early education, parenting skills, child abuse prevention, and nutrition education or assistance."[44] North Carolina is using the grant to support existing efforts to build evidence-based home visiting programs focused on improving the well-being of families with young children. To continue receiving funding and to potentially expand the program to reach more recipients, initial recipients must report quarterly results on selected benchmarks and show measureable change in outcomes in three-years.

Durham County is testing another promising practice called Durham Connects. This initiative provides in-home nurse visits to all parents of newborns born in Durham County. The program has shown improvements in health outcomes and is being expanded as a model to select northeastern counties as part of the Race to the Top–Early Learning Challenge Grant. (See Chapter 2 for more information on the grant.) In addition to these evidence-based and promising home visiting programs, Newborn Home Visit Services are available for all newborns by contacting the local health department. In this program, a nurse visits the baby and caregiver in the home to provide information on infant health and care, follow up on the newborn screening, and provide education and social support.

c The seven agencies selected are the following: the Buncombe County Department of Health Center (Buncombe county); Barium Springs Home for Children (lesser Burke county); Center for Child and Family Health (northeast and central Durham, 120 blocks); Gaston County Health Department (Gaston, 38 census tracks); Northampton County Health Department (serving Northampton, Halifax, Edgecombe, and Hertford Counties); Robeson County Health Department (Robeson and Columbus Counties); the Toe River Health Department (Mitchell and Yancey Counties).

Family Strengthening and Parenting Skills Programs

In addition to home visiting programs, the Division of Public Health (DPH), Smart Start, Prevent Child Abuse North Carolina, the Division of Social Services (DSS), and others support family strengthening and parenting skills programs. For example, DPH funds family strengthening programs through the Adolescent Parenting Program, local health departments, and as part of pilot programs such as NC Launch and the Race to the Top–Early Learning Challenge Grant transformation zone. These programs include elements such as teaching parents the basics of child development and positive parenting techniques, promoting children's cognitive and social-emotional development, and helping families connect with support services. Evidence-based family strengthening and parenting skills being implemented in North Carolina include Triple P, Incredible Years, Incredible Years BASIC Preschool Parent Training Program, Parents as Teachers, Nurse-Family Partnership, Healthy Families, and Strengthening Families. (See Appendix B for more information about these programs.) Additionally, other foundations, organizations, and religious entities provide funding for evidence-based family strengthening and parenting skills programs in their communities.

There is a great need for evidence-based in–home and out-of-home programs to improve family functioning and parenting skills and to help families connect with needed services and supports. (See Recommendation 2.2 in Chapter 2 and Recommendation 3.3 in Chapter 3.) These types of preventive programs are designed to work with all families. However, due to limited resources they are typically targeted to families and children who are deemed to have risks. Families may be defined as having risks for a number of reasons including low family income, parental substance use, children with identified behavioral problems, and family involvement with DSS due to allegations of neglect or maltreatment. Evidence-based family strengthening and parenting skills programs positively impact the social-emotional development of young children who are at-risk for poor development. However, due to the small nature of most of these programs, the variety of funders and venues for access, the variation in availability and eligibility across counties, and the lack of knowledge about such programs, it can be difficult for parents to get connected to these beneficial programs. There is a need for an easy way for parents and families to find information on programs and services to support young children's social-emotional development and mental health. Therefore, the Task Force recommends:

Recommendation 4.1: Develop a Web-Based Clearinghouse of Programs and Services for Young Children with Mental Health Needs

North Carolina private foundations and other funding sources should provide $125,000 to the North Carolina Infant and Young Child Mental Health Association, Early Childhood Advisory Council, and other partners to develop, deploy, and maintain a web-based clearinghouse of information on programs and services available to children and families with mental health, social, and emotional needs at the state and county level. Information provided should include availability, eligibility criteria, costs, and evidence about the effectiveness of the programs and services.

Additionally, there is a need to expand evidence-based programs providing prevention and early intervention to address the social-emotional and mental health needs of young children and their families. (See Recommendation 2.2 in Chapter 2 and Recommendation 3.3 in Chapter 3.) There is also a need to increase the knowledge and skills of the early care and education provider workforce so they are better able to foster young children's social-emotional development and mental health. For more information on existing efforts and recommendations, see Chapter 2.

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